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SECTION I - INTRODUCTION

I. INTRODUCTION

This new edition of the Kentucky Medical Assistance Program Family Planning Services Manual has been formulated with the intention of providing you, the provider with a useful tool for interpreting the procedures and policies of the Kentucky Medical Assistance Program. It has been designed to facilitate the processing of your claims for services provided to qualified recipients of Medicaid.

This manual is intended to provide basic information concerning coverage, billing, and policy. It will, hopefully, assist you in understanding what procedures are reimbursable, and will also enable you to have your claims processed with a minimum of time involved in processing rejections and making inquiries. It has been arranged in a loose-leaf format, with a decimal page numbering system which will allow policy and procedural changes to be transmitted to you in a form which may be immediately incorporated into the manual (i.e., page 7.6 might be replaced by new pages 7.6 and 7.7).

Precise adherence to policy is imperative. In order that your claims may be processed quickly and efficiently, it is extremely important that you follow the policies as described in this manual. Any questions concerning general agency policy should be directed to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-4321. Questions concerning the application or interpretation of agency policy with regard to individual services should be directed to the Division of Policy and Provider Services, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-3476. Questions concerning billing procedures or the specific status of claims should be directed to EDS, P.O. Box 2009, Frankfort, KY 40602, or Phone (800) 372-2921 or (502) 227-2525.

SECTION I - INTRODUCTION

B. Fiscal Agent

Effective December 1, 1983, Electronic Data Systems (EDS) began providing fiscal agent services for the operation of the Kentucky Medicaid Management Information System (MMIS). EDS receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

II. KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

A. General

The Kentucky Medical Assistance Program, frequently referred to as the Medicaid Program, is administered by the Department for Human Resources, Bureau for Social Insurance, Division for Medical Assistance. The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the U. S. Department of Health and Human Services.

Title XIX is a joint Federal and State assistance program which provides payment for certain medical services rendered to Kentucky recipients who lack sufficient income or other resources to meet the cost of such care. The basic objective of the Kentucky Medical Assistance Program is to aid the medically indigent of Kentucky in obtaining quality medical care.

As a provider of medical services, you must be aware that the Division for Medical Assistance is bound by both Federal and State statutes and regulations governing the administration of the State Plan. The Division cannot reimburse you for any services not covered by the plan. The state cannot be reimbursed by the federal government for monies improperly paid to providers of non-covered unallowable medical services.

The Kentucky Medical Assistance Program, Title XIX, Medicaid, is not to be confused with Medicare. Medicare is a Federal program, identified as Title XVIII, basically serving persons 65 years of age and older, and some disabled persons under that age.

The Kentucky Medicaid Program serves eligible recipients of all ages. The coverage, either by Medicare or Medicaid, will be specified in the body of this manual in Section IV.

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

B Administrative Structure

The Division for Medical Assistance, within the Bureau for Social Insurance of the Department for Human Resources, bears the responsibility for developing, maintaining, and administering the policies and procedures, scopes of benefits, and basis for reimbursement for the medical care aspects of the Program The Division for Medical Assistance makes the actual payments to the providers of medical services, who have submitted claims for services within the scope of covered benefits which have been rendered to eligible recipients.

Determination of the eligibility status of individuals and families for Medical Assistance benefits, is a responsibility of the local Bureau for Social Insurance Offices, located in each county of the state.

C. Advisory Council

The Kentucky Medical Assistance Program is guided in policy-making decisions by the Advisory Council for Medical Assistance. In accordance with the conditions set forth in KRS 205.540, the Council is composed of fifteen members, including the Secretary of the Department for Human Resources, who serves as an ex officio member. The remaining fourteen members are appointed by the Governor to four-year terms. Nine members represent the various professional groups providing services to Program recipients, and are appointed from a list of three nominees submitted by the applicable professional associations. The other five members are lay citizens.

In accordance with the statutes, the Advisory Council meets at least every three months and as often as deemed necessary to accomplish their objectives.

In addition to the Advisory Council, the statutes make provision for a five-member technical advisory committee for certain provider groups. Membership on the technical advisory committees is decided by the professional organization that the technical advisory committee represents. The technical advisory committees provide for a broad professional representation to the Advisory Council.

As necessary, the Advisory Council appoints sub-committees or ad hoc committees responsible for studying specific issues and reporting their findings and recommendations to the Council.

D. Policy

The basic objective of the Kentucky Medical Assistance Program hereinafter referred to as KMAP, is to assure the availability and accessibility of quality medical care to eligible Program recipients.

The 1967 amendments to the Social Security Law stipulates that Title XIX Programs have secondary liability for medical costs of Program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party is primarily liable for the patient's medical expenses. The Medical Assistance Program has secondary liability. Accordingly, the provider of service should seek reimbursement from such third party groups for medical services rendered. If you, as the provider, should receive payment from the KMAP before knowing of the third party's liability, a refund of that payment amount should be made to the KMAP, as the amount payable by the Department shall be reduced by the amount of the third party obligation.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers must agree to provide services in compliance with federal and state statutes regardless of sex, race, creed, religion, national origin, handicap, or age.

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

Each medical professional is given the choice of whether or not to participate in the Kentucky Medical Assistance Program. From those professionals who have chosen to participate, the recipient may choose the one from whom he wishes to receive his or her medical care.

When the Department makes payment for a covered service and the provider accepts the payment made by the Department in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; and no bill for the same service shall be tendered to the recipient, or payment for the same service accepted from the recipient.

Providers of medical service attest by their signatures (not facsimiles) that the presented claims are valid and in good faith. Fraudulent claims are punishable by fine and/or imprisonment.

All claims and substantiating records are auditable by both the Government of the United States and the Commonwealth of Kentucky.

All claims and payments are subject to rules and regulations issued from time to time by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services to recipients of this Program shall be on a level of care at least equal to that extended private patients, and normally expected of a person serving the public in a professional capacity.

All recipients of this Program are entitled to the same level of confidentiality accorded patients <u>not</u> eligible for Medicaid benefits.

Professional services shall be periodically reviewed by peer groups within a given medical specialty.

All services are reviewed for recipient and provider abuse. Willful abuse by the provider may result in his or her suspension from Program participation. Abuse by the recipient may result in surveillance of the payable services he or she receives.

No claim may be paid for services outside the scope of allowable benefits within a particular specialty. Likewise, no claims will be paid for services that required, but did not have, prior authorization by the Kentucky Medical Assistance Program.

No claims may be paid for medically unnecessary items, services, or supplies.

When a recipient makes payment for a covered service, and such payment is accepted by the provider as either partial payment or payment in full for that service, no responsibility for reimbursement shall attach to the Cabinet and no bill for the same service shall be paid by the Cabinet.

When a Medicaid eligible patient must return to the clinic for completion of an Initial/Annual pap smear, no claim is to be submitted for this visit. This would be considered a completion of the Initial/Annual. Patient record documentation should reflect the reason for the return visit.

The same principle as above applies to the Medicaid patient who must return and also must receive supplies. In view of the fact that the contraceptive method is considered a part of the reimbursement for the first visit, no additional claim may be submitted. The Medicaid patient must not be assessed a fee nor shall the Medicaid program be billed for the supplies.

Medicaid policy states that the Family Planning clinic is required to diagnose and treat or refer patients with vaginal infections. The medication is to be provided at the time of the visit. No other claim may be submitted if the patient returns for the sole

purpose of picking up the medication. The Medicaid patient must not be assessed a fee nor shall the Medicaid program be billed for the medication issued. In the event that physician prescribes a medication not routinely provided by the clinic, the patient may be given a prescription to take to the pharmacy or the patient may be referred to her private physician.

If a Medicaid recipient comes to the clinic for a free pregnancy test and counseling on the results, no claim shall be submitted to the Medicaid program.

Exception: If a patient receive contraceptive supplies and counseling in addition to a pregnancy test and counseling, a claim for a supply/counseling visit may be submitted.

If an ARNP requests the Medicaid patient to return to the clinic to see the physician due to a suspected problem, a bill may be submitted for both visits. The visit by the physician would be billed using the appropriate procedure code for a follow-up visit by the physician. The charge must be entered on the MAP-4.

Return visits for the Medicaid patient receiving counseling due to an abnormal pap smear are payable. The counseling code would be used to reflect the medical professional.

A post-diaphragm fitting check for a Medicaid patient is payable as a follow-up visit. The charge must be entered on the MAP-4.

A Medicaid patient's post partum visit is payable. The actual type of visit to be billed will be determined by the following:

1. New patient - Bill an Initial

2. Established patient - Determine the length of time since the last visit. If it has been at least nine months, bill an Annual. If it has been less than nine months, bill a follow-up. Determine at what point the nine months will lapse and reschedule the patient for an Annual.

Split billing of the Initial or Annual is not acceptable to the Medicaid program.

In the event a recipient comes to the clinic shortly before her actual scheduled Initial or Annual and any services exceeding those required for a counseling/supply visit are provided, for example, lab work, no claim for this visit may be submitted. These services, including the lab work, are considered part of the Initial or Annual and this is considered preliminary work-up for the Initial or Annual.

If, however, the patient visits the clinic shortly before the scheduled Initial or Annual and the only service that is provided is Counseling/ Supply, a claim may be submitted for that visit.

E. Public Law 92-603 (As Amended)

Section 1909. (a) Whoever--
(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,
(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,
(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

F. Timely Submission of Claims

In order to receive Federal Financial Participation, claims for covered services rendered eligible Title XIX recipients must be received by the Department for Medicaid Services within twelve (12) months from the date of service. Claims received after that date will not be payable. This policy became effective August 23, 1979.

G. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which, as an adjunct to the Kentucky Medical Assistance Program (KMAP), provides certain categories of medical recipients with a primary physician or family doctor. Only those Medicaid recipients who receive medical assistance under the Aid to Families with Dependent Children (AFDC), or AFDC-related categories are covered by KenPAC. Specifically excluded are: the aged, blind, and disabled categories of recipients; skilled nursing facility (SNF), intermediate care facility (ICF), and personal care (PC) residents; mental hospital patients; foster care cases; refugee cases; all spend-down cases; and all Lock-In cases. To aid in distinguishing from regular KMAP recipients, the KenPAC recipients will have a green KMAP card with the name, address, and telephone number of their primary care provider.

Under KenPAC the following service categories must be either provided by the primary physician or referred by the primary physician in order to be reimbursed by Kentucky Medicaid.

-Physician (excludes KMAP recognized Ophthalmologists, Psychiatrists, and OB/GYN provided obstetrical services)
-Hospital (Inpatient and Outpatient)
-Laboratory Services
-Nurse Anesthetists
-Rural Health Clinic Services
-Home Health
-Primary Care Centers
-Ambulatory Surgical Centers

Family Planning Clinic Services are exempt from the required referral and may be obtained at the option of the KenPAC recipient in the usual manner.

In the event you make a referral to one of the service elements listed above, you are to contact the primary care physician for his/her Medicaid provider number. This number is <u>not</u> to be entered on the billing form. The acquisition of this number is solely for the use by the medical professional to whom the referral is being made.

SECTION III - CONDITIONS OF PARTICIPATION

III. CONDITIONS OF PARTICIPATION

Provider

As the size and spacing of families so profoundly relates to the physical and emotional health of individuals and families, it is the objective of the Family Planning Services element to provide each recipient of reproductive age with complete information regarding available contraceptive methods and infertility services, and to assure that each recipient receives the devices and services required.

Any family planning agency meeting the participation requirements outlined herein is eligible to submit to the KMAP appropriate forms as designated on page 3.20. Determination of provider eligibility and certification for participation will be accomplished by the Department for Medicaid Services.

A. Administration

1. The family planning agency shall name an administrative director, who shall be responsible for assuring that the requirements for participation are met and that the procedures established by the Program are carried out. The family planning agency shall have on its staff a physician, duly licensed, who shall be responsible for development and implementation of the agency's medical policies and procedures and shall generally supervise and evaluate the medical components of the ongoing program.

2. The participating agency shall keep on file administrative policies, detailing the agency's organizational structure, with lists of all personnel, their position classifications, and specific areas of responsibility assigned to each. Also included shall be a description of services rendered in the agency, with explicit guidelines for referral and follow-up services, a description of medical records kept, and a list of equipment and supplies maintained by the agency.

3. The family planning clinic can bill only for services actually performed.

4. The clinic should select the HCPC-Local code which most accurately and completely describes the actual service performed.

5. The charge made to the KMAP should be the same charge made for comparable services provided to any party or payor.

6. If a provider is terminated from KMAP participation, services provided after the effective date of termination are not payable.

B. Staff

1. Director -- The agency shall have an administrative director, who shall be responsible for assuring that the requirements for participation are met and that the procedures established by the Program are carried out.

2. Physician -- The agency shall have at least one physician, who has a current, valid license to practice at the time the medical services or procedures are performed; who shall be responsible for all medical aspects of the program, and who shall perform direct medical services as indicated.

3. Nurse -- The agency shall have at least one professional registered nurse, who shall function under the supervision of the physician and the administrative director to assure the efficient provision of required services in accordance with health care standards described herein.

4. Other Staff -- The agency shall have the necessary supportive staff, paramedical and clerical, to assure the performance of services outlined herein.

   All staff shall be trained and their services limited to their area of competence and in accordance with the professional practice acts governing the health disciplines.

NOTE: Reimbursement for services rendered by an Advanced Registered Nurse Practitioner (ARNP) will be made to participating agencies providing the Guidelines for the Utilization of the Advanced Registered Nurse Practitioner are followed. (See Appendix VII-F)

SECTION III - CONDITIONS OF PARTICIPATION

C. Available Services

The family planning agency shall make available to each recipient at least the following services. When a service cannot be provided by the agency itself, the agency shall be responsible for referral to and acceptance of the recipient by an appropriate source.

1. Initial Clinic Visit

a. Complete Medical History--A complete medical history shall be obtained and recorded, along with relevant family history. The history shall include, but not be limited, to:

1) Complete obstetrical history, with menarche and menstrual history, last menstrual period, gravidity, parity, pregnancy outcomes, and complications of any pregnancy and/or delivery.

2) Any significant illnesses, hospitalizations, and previous medical care and the indicated systems review, e.g., cardiovascular, renal, neurologic, hepatic, endocrine, hematologic, gynecologic (Dysmenorrhea, metrorrhagia, menorrhagia, post-coital bleeding, vaginal discharge, dyspareunia) and venereal disease.

3) Previous contraceptive devices or techniques used, and problems related to their use.

d. Information and Education Regarding Contraceptive Methods--The recipient shall be given comprehensive, detailed information concerning reversible and irreversible contraceptive methods available. This information shall include mode of action, advantages and disadvantages, effectiveness, and common side effects of each method. Basic information concerning venereal disease shall also be given.

At the outset of the discussion, the recipient's level of knowledge regarding reproductive functions shall be established and basic information presented where necessary.

Ample time shall be given for the recipient to ask pertinent questions and to relate the presented information to his/her personal situation.

e. Prescription of Contraceptive Method--The physician shall prescribe the contraceptive method, based on the medical and psychiatric history, the medical examination, laboratory tests, and the recipient's wishes. The physician or the registered nurse shall give complete verbal instructions as to use of the method, and the recipient shall also be given complete written instructions.

ARNP limitations will be based on the written protocols as they relate to the specific contraceptive method.

ALL OF THE PRECEDING SERVICES MUST BE COMPLETED AND DOCUMENTED BEFORE A VENDOR CAN BILL FOR AN INITIAL EXAMINATION.

2. Revisits by Contraceptive Patients--Scheduled

Subsequent visits to the clinic shall be scheduled at least annually and in accordance with the contraceptive method prescribed.

a. Oral Contraceptive Recipients shall return to the clinic not later than three months after the initial prescription is issued, and thereafter not less frequently than annually. Revisits scheduled at 3 month intervals are not required unless recommended by the physician and/or medically indicated.

During the first scheduled follow-up visit, at least the following services shall be provided:

1) An interim history, to include pain (especially in the arms and chest), headaches and visual problems, mood changes, leg complaints, vaginal bleeding and/or discharge, and VD history

2) Review of menstrual history

3) Blood pressure, weight check

4) Laboratory tests as indicated

b. I.U.D. Recipients shall return to the clinic not later than three months following insertion of the device, at which time at least the following services shall be provided:

1) A repeat pelvic examination with visual inspection of the cervix

2) Blood pressure and weight

3) Menstrual history review

4) Review of abdominal symptoms, fever, vaginal bleeding/ discharge

5) Laboratory tests as indicated

Revisits scheduled at 3 month intervals are not required unless recommended and/or medically indicated.

c. Diaphragm Recipients shall be seen within two to four weeks after initial fitting, to assure that the recipient can insert, position, and remove the diaphragm correctly.

d. Rhythm Method--Recipients using the rhythm method shall be seen in one month after initial visit, for instruction and assessing complaints, and six months thereafter, for review of menstrual calendar and temperature charts.

e. Other--Recipients using other methods of contraception do not require a routine follow-up visit for medical review or examination prior to the required annual visit.

The KMAP can make reimbursement for counseling and/or supply visits rendered to males, providing the recipients were eligible at the time the services were rendered.

3. Annual Visits

Annual visits are required for all contraceptive recipients. During these visits, at least the following services shall be provided:

a. Interim health history to update all medical and psychiatric information required in the initial history.

b. Complete physical examination, by the physician or ARNP, including all procedures required during the initial physical exam.

c. Repeat of initial laboratory and clinical procedures detailed in Section C.1.c., page 3.04.

d. Evaluation of use of current method of contraceptive and change in prescription when indicated. Any change shall be based on interim medical and psychiatric history, physical examination and laboratory tests, and the recipient's satisfaction and success with the current method.

e. Complete verbal and written instructions if prescription is changed.

4. Follow-Up Services

Any recipient who fails to keep an appointment for a scheduled contraceptive visit, or who discontinues use of the prescribed contraceptive method, shall be contacted by agency personnel and the reason determined. Encouragement and any possible aid shall be given to the recipient to insure continued enrollment in the agency's program. The KMAP cannot reimburse the vendor for counseling visits outside a clinic setting.

5. Revisits by Recipient -- Unscheduled.

Recipients shall be encouraged to return to the clinic whenever they have specific problems related to the contraceptive method or wish additional guidance, service, or contraceptive supplies.

6. Voluntary Sterilization

Counseling services involving transmittal of complete information regarding male and/or female sterilization procedures shall be provided the individual or couple requesting such services, plus full information concerning alternate methods of contraception. These counseling services shall be provided by the physician, the registered nurse, or the ARNP following those services required during any initial contraceptive visit to the clinic, and shall meet at least the following conditions:

a. The recipient's level of knowledge regarding reproductive functions shall be assessed, and proper instruction given where needed.

b. A full discussion of reversible contraceptive methods shall be given.

c. The recipient shall be made fully aware that the sterilization procedure will most likely be irreversible.

d. Sterilization procedures shall be explained in detail, with use of charts or body models.

e. The recipient shall be given complete information concerning possible complications and failures.

f. The relative merits of male versus female sterilization shall be discussed with both partners, if both are available.

g. The recipient shall be given information relating to the fact that sterilization does not interfere with sexual function or pleasure.

h. The function of the counselor is to provide information, and he/she shall in no way seek to influence the recipient to be sterilized.

SECTION III - CONDITIONS OF PARTICIPATION

The following conditions shall be considered contraindications for voluntary sterilization:

a. The recipient has physical, mental, or emotional conditions which could be improved by other treatment.

b. The recipient is suffering from temporary economic difficulties which may improve.

c. The recipient or couple feel that they are not yet ready to assume the responsibilities of parenthood.

d. The recipient expresses possible wish to reverse the procedure in case of a change of circumstances.

If sterilization is not desired, alternate methods of contraception shall be discussed.

If the recipient decides to be sterilized, the clinic shall be responsible for the referral to and acceptance of the recipient by the proper medical source. In addition, the clinic shall:

a. Inform the recipient that in accordance with new Federal regulations, a 30 day waiting period is required from the time the Consent to Sterilization Form is signed.

b. Provide information and instructions concerning need for follow-up, particularly for males.

c. Provide all males undergoing vasectomy with appropriate post-operative semen analysis.

If the recipient is married and resides with the spouse, the agency may also wish to obtain the written informed consent of the spouse.

NOTE: Family Planning Clinics are no longer required to obtain the patient's signature on a consent form to attest to counseling. Clinics are, however, required to document, in detail, all pertinent counseling and referral information.

7. Infertility Services

Provision shall be made for screening and diagnosis of fertility problems. Recipients requesting infertility services shall receive complete physical exam and history, shall be given full information concerning reproductive functions, available tests and possible remedial procedures, and shall be referred to and accepted by a medical provider who can make available at least the following services:

a. Complete history and physical examinations of both partners.

b. G.C. and serologic testing of both partners.

c. Basal body temperature monitoring.

d. Semen analysis.

e. Cervical mucus examination.

f. Vaginal smear for assessment of estrogen production.

g. Endometrial biopsy.

h. Hysterosalpingogram.

8. Vaginal Infections

The clinic shall be responsible for diagnosis and treatment or referral of recipients suffering from vaginal infections.

9. Emergency Services

Provision shall be made for handling emergencies related to contraceptive services when the clinic is not in session.

10. Inpatient Services

Provision shall be made for inpatient care of recipients whose hospitalization is necessitated by complications arising from contraceptive services provided. The agency shall have on file a formal, written affiliation agreement with at least one area hospital.

11. Pregnancy Testing

The clinic shall provide pregnancy testing on request by the recipient, when indicated by the history or physical examination, or when the prescribed method of contraception would indicate need for same.

12. Referrals

The clinic shall be responsible for referral to the proper resource in the following circumstances, and for ensuring that the recipient is accepted by the resource to which he/she is referred.

a. Medical problems indicated by history, physical examination, or laboratory or clinical test.

b. For pregnancy related services when appropriate.

c. For social case work not appropriately handled by agency personnel.

d. For abortion counseling.

D. Supplies

The family planning agency shall make available to the recipient, on a continuing basis where applicable, at least the following contraceptive supplies:

1. Oral contraceptives
2. Intrauterine devices
3. Diaphragms
4. Foams
5. Thermometers for rhythm method
6. Jellies and Creams
7. Condoms

E. Medical Records

The family planning agency shall maintain complete recipient medical records, which shall contain but not be limited to the following:

1. Initial and interim histories -- medical, psychiatric, and social.

2. Record of initial and interim physical examinations.

3. All laboratory reports.

SECTION III - CONDITIONS OF PARTICIPATION

G. Availability of Services

Services of the family planning agency shall be available to each and every person requesting same, regardless of sex, race, age, income, number of children, marital status, citizenship or motive.

H. Physical Facilities

The agency shall be located in an area that is constructed, equipped and maintained to insure the safety of the recipients and provide a functional, sanitary environment. The area utilized by the family planning clinic must be adequate in space and design to provide non-surgical family planning services specified in Section IV, with setting and atmosphere to insure respect for the privacy and dignity of individuals during medical examinations, counseling, and interviews.

I. Equipment

The agency shall have the necessary equipment to provide the services detailed in Section III. C. Available Services.

J. Termination of Participation

904 KAR 1:220 regulates the terms and conditions of provider participation and procedures for provider appeals. The Cabinet for Human Resources determines the terms and conditions for participation of vendors in the Kentucky Medical Assistance Program and may suspend, terminate, deny or not renew a vendor's provider agreement for "good cause." "Good cause" is defined as:

1. Misrepresenting or concealing facts in order to receive or to enable others to receive benefits;

2. Furnishing or ordering services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized health care standards;

3. Misrepresenting factors concerning a facility's qualifications as a provider;

4. Failure to comply with the terms and conditions for vendor participation in the program and to effectively render service to recipients; or

5. Submitting false or questionable charges to the agency.

The Kentucky Medical Assistance Program shall notify a provider in writing at least fifteen (15) days prior to the effective date of any decision to terminate, suspend, deny or not renew a provider agreement. The notice will state:

1. The reasons for the decision;

2. The effective date;

3. The extent of its applicability to participation in the Medical Assistance Program;

4. The earliest date on which the Cabinet will accept a request for reinstatement;

5. The requirements and procedures for reinstatement; and

6. The appeal rights available to the excluded party.

The provider receiving such notice may request an evidentiary hearing. The request must be in writing and made within five (5) days of receipt of the notice.

The hearing shall be held within thirty (30) days of receipt of the written request, and a decision shall be rendered within thirty (30) days from the date all evidence and testimony is submitted. Technical rules of evidence shall not apply. The hearing shall be held before an impartial decision-maker appointed by the Secretary for Human Resources. When an evidentiary hearing is held, the provider is entitled to the following:

1. Timely written notice as to the basis of the adverse decision and disclosure of the evidence upon which the decision was based;

IV. SERVICES COVERED

The KMAP will make payment to participating family planning agencies for required services provided to all eligible Title XIX recipients. These services are to be billed under the following categories.

A. Initial Clinic Visit

The initial clinic visit shall be billed to the Program for services provided a new recipient during his/her first visit to the agency. The recipient must be examined by the physician or ARNP, with all services listed under III.C.1. being rendered. When the recipient requests other specifically covered services, such as voluntary sterilization or infertility services, additional requirements detailed in the appropriate section of III.C. Available Services must also be met.

1. Program payment for the visit shall be considered payment in full for the following. Any expenses incurred by the agency in provision of these services or items, such as laboratory services rendered by another provider, shall be considered the responsibility of the agency, and neither the Program, the recipient, nor any other source may be billed additional amounts for these services or items.

   a. All services, including history, physical examination, laboratory procedures and counseling required under III.C.1. Initial Clinic Visit.

   b. All supplies and materials used during the visit.

c. All medications and contraceptive devices or supplies dispensed to the recipient.

d. Diagnosis and treatment or referral for treatment of vaginal infection.

e. Pregnancy testing.

f. Sterilization and infertility counseling.

g. Referral services.

B. Annual Clinic Visit

Payment will be made for an annual clinic visit, during which the recipient must be examined by the physician or ARNP. This visit shall include all services required under Section III.C.3. Annual Visits. If the recipient should request a sterilization or other specifically covered service, any additional requirements applicable to that service must also be met.

C. Follow-up Visit With Pelvic Examination

The follow-up visit with pelvic examination is to be billed for any visit to the agency other than the initial or annual visit, during which the recipient is seen by the physician or ARNP and receives a pelvic examination. Such visits may be follow-up visits routinely scheduled for a given contraceptive method, or may be initiated by the recipient because of some contraception-related medical problem.

D. Follow-Up Visit Without Pelvic Examination

The followup visit without pelvic examination is to be billed for any visit to the agency during which the recipient is examined by the physician or ARNP but does not receive a pelvic examination. Such visits may be follow-up visits routinely scheduled for a given contraceptive method, or may be initiated by recipients because of contraception-related problems which require examination by a physician.

E. Counseling Visit

The counseling visit is to be billed for any clinic visit or follow-up visit during which counseling services are rendered the recipient by the physician or by other agency staff. Such visits may be follow-up visits routinely scheduled for a given contraceptive method, or may be initiated by recipients whose contraception-related problems do not require examination by a physician.

The counseling visit may involve taking of an interim medical history, blood pressure check, and other such services rendered by agency paramedical staff. It may also be billed when the recipient requires additional information from the physician, ARNP, or paramedical staff regarding the chosen contraceptive method, or simply needs assurance.

Payment for a counseling visit may not be requested when the recipient visits the agency for the sole purpose of obtaining contraceptive supplies, and has no contraception-related problems which require a substantial amount of staff time.

The KMAP cannot make reimbursement for counseling services rendered outside a clinic setting.

F. Supply Only Visit

The supply only visit is to be billed when the recipient visits the agency for the sole purpose of obtaining contraceptive supplies. Program payment for the supplies dispensed is to be considered payment in full for those supplies.

NOTE: Dispensing of any family planning supplies must be in accordance with all applicable laws and regulations.

If the recipient visits the agency for the purpose of obtaining supplies, but has a contraception-related problem which requires the physician or ARNP's attention or considerable counseling services from other agency staff, the appropriate type of visit, rather than a "Supply Only Visit" should be billed.

G. Contraceptive Emergency Services

If emergencies related to contraceptive services occur when the clinic is not in session, the Program will make payment to an appropriate participating medical provider for the services and/or items required, within the limitations of the particular Program element.

H. Inpatient Services

If a clinic recipient requires inpatient care as a result of complications arising from contraceptive services provided by the clinic, the Program will make payment for that care within the limitations of the hospital inpatient element, contingent on the recipient's continuing technical eligibility.

SECTION IV - SERVICES COVERED

I. Referrals

The Program will make payment to the appropriate medical provider for covered services provided on referral from the family planning agency, within the scope and policies of the Program.

J. Limitations of Covered Services

1. Initial Visit

The Initial Visit is to be billed when a patient visits the clinic for the first time. The patient should be seen annually thereafter. Therefore, the Initial Visit is limited to one, per patient, per clinic.

2. Multiple Services

Family Planning Services are limited to one service per date of service. More than one clinic visit is not allowed on the same day.

3. Annual Visit

The Annual Family Planning Clinic Visit is limited to one per patient per nine months. There must be at least nine months between the patient's Initial Visit and the first Annual Visit and at least nine months between Annual Visits.

4. Limits on Birth Control Medication

The Department for Medicaid Services has adopted the following policy with regard to Program coverage for birth control medication. This policy applies to those patients who must present a prescription for Birth Control medications that are not routinely covered by the clinic.

a. The Program will reimburse for no more than one prescription per day for birth control medication per Medicaid recipient.

b. The Program will reimburse for no more than a total of 13 prescriptions in any calendar year for a given Medicaid patient.

c. Through the Program's Drug Utilization Review (DUR) subsystem, an in-depth review will be accomplished in any instance where a Medicaid recipient is receiving more than the appropriate amount of birth control medication (i.e, exceeds a thirty (30) day supply in a thirty (30) day period). The purpose of the review will be to determine the reason of the excess supply, and to recommend appropriate action to address the excess supply.

SPECIAL NOTE: NON-COVERED SERVICES

Counseling visits rendered outside a clinic setting

B. Duplicate or Inappropriate Payments

Any duplicate or inappropriate payment by the KMAP, whether due to erroneous billing or payment system faults, must be refunded to the KMAP. Refund checks should be made payable to "Kentucky State Treasurer" and sent immediately to:

EDS
P.O. Box 2009
Frankfort, KY 40602

ATTN: Cash/Finance Unit

Failure to refund a duplicate or inappropriate payment could be interpreted as fraud or abuse, and prosecuted as such.

C. Third Party Coverage (Excluding Medicare)

1. General

To expedite the Medicaid claims processing payment function, the provider of Medicaid services must actively participate in the identification of third party resources for payment on behalf of the recipient. At the time the provider obtains Medicaid billing information from the recipient, he/she should determine if additional resources exist. Providers have an obligation to investigate and to report the existence of other insurance or liability. The provider's cooperation will enable the Kentucky Medicaid program to function efficiently.

2. Identification of Third Party Resources

Pursuant to KRS 205.662, prior to billing the Kentucky Medical Assistance Program all participating vendors shall submit billings for medical services to a third party when such vendor has prior knowledge that such third party may be liable for payment of the services.

SECTION V - REIMBURSEMENT

In order to identify those recipients who may be covered through a variety of health insurance resources, the provider should inquire if the recipient meets any of the following conditions:

- -If the recipient is married or working, inquire about possible health insurance through the recipient's or spouse's employer;
- -If the recipient is a minor, ask about insurance the mother, father, or guardian may carry on the recipient;
- -In cases of active or retired military personnel, request information about CHAMPUS coverage and social security number of the policy holder;
- -For people over 65 or disabled, seek a Medicare HIC number;
- -Ask if the recipient has health insurance such as a Medicare Supplement policy, cancer, accident, or indemnity policy, group health or individual insurance, etc.

Examine the recipient's MAID card for an insurance code. If a code indicates insurance coverage, question the recipient further regarding the insurance.

Following is a list of the insurance codes on the MAID card:

A - Part A, Medicare only
B - Part B, Medicare only
C - Both Parts A and B Medicare
D - Blue Cross/Blue Shield
E - Blue Cross/Blue Shield/Major Medical
F - Private medical insurance
G - Champus
H - Health Maintenance Organization
J - Other and/or unknown
L - Absent Parent's insurance
M - None
N - United Mine Workers
P - Black Lung

3. Billing Instructions for Claims Involving Third Party Resources

If the patient has third party resources that will cover the services being billed, then the provider must obtain payment or rejection from the third party before Medicaid can be filed. When payment is received, the provider should indicate on the claim form in the appropriate field the amount of the third party payment and the name and policy numbers of health insurance covering the recipient. If the third party rejected the claim, a copy of the rejection notice must be attached to the Medicaid claim.

Exceptions:

*If the other insurance company has not made payment within 120 days of date of filing a claim to the insurance company, submit with the Medicaid claim a copy of the other insurance claim to EDS indicating "NO RESPONSE" on the Medicaid claim form. Then forward a completed TPL Lead form to:

EDS
P.O. Box 2009
Frankfort, KY 40602
Attn: TPL Unit

*If proof of denial for the same recipient for the same or related services from the carrier is attached to the Medicaid billing, claims processing can proceed. The denial cannot be more than six months old.

*A letter from the provider indicating that he/she contacted XYZ insurance company and spoke with an agent to verify that the recipient was not covered, can also be attached to the Medicaid claim.

SECTION VI - COMPLETION OF INVOICE FORM

VI. COMPLETION OF INVOICE FORM

A. General Billing Information

The Health Insurance Claim Form (HCFA-1500) should be used to bill for services rendered to eligible KMAP recipients by a participating Family Planning Agency. Typing of the invoice form is strongly urged, since an invoice cannot be processed and paid unless the information supplied is complete and legible.

The original of the two part invoice set should be submitted to EDS as soon as possible after service is provided. The carbon copy of the invoice should be retained by the provider's office as a record of claim submittal.

Invoices should be mailed to:

EDS
P.O. Box 2018
Frankfort, Kentucky 40602

B. Procedural Coding

On May 1, 1985, KMAP adopted for procedural coding purpose, the HCFA Common Procedural Coding System (HCPCS).

C. Completion of HCFA-1500

An example of a HCFA-1500 is shown in Appendix VII. Instructions for the proper completion of this form are presented below.

A supply of HCFA-1500 may be obtained by contacting:

Blue Cross/Blue Shield of Kentucky
9901 Linn Station Road
Louisville, Kentucky 40223

SECTION VI - COMPLETION OF INVOICE FORM

IMPORTANT: The patient's Kentucky Medical Assistance Identification Card should be carefully checked to see that the patient's name appears on the card and that the card is valid for the period of time in which the medical services are to be rendered. You cannot be paid for services rendered to an ineligible person.

Program payment will be made if the patient is eligible at the time the service is rendered and if the claims for services are received by the KMAP within 1 year (12 months) of the date of service.

Block No. Description

1. RECIPIENT'S NAME:

Enter the recipient's last name, first name, and middle initial as indicated on the MAID Card.

6. INSURED'S ID NUMBER:

Enter the recipient's 10-digit MAID Number exactly as it appears on the current MAID Card.

9. OTHER HEALTH INSURANCE, IF APPLICABLE:

Complete if the recipient has any other kind of health insurance applicable to this service, other than Medicare. Enter the name and address of the insurer and the policy number. The amount paid by the insurance company should be listed in Block #28. Private insurance must be billed prior to billing the KMAP.

19. REFERRING PHYSICIAN:

Required for referred KenPAC and Lock-In recipients. Enter the 8-digit KMAP provider number of the referring KenPAC or Lock-In provider. Enter only one referring KenPAC provider number.

23A. DIAGNOSIS OF NATURE OF ILLNESS:

Enter the ICD-9-CM diagnosis code for the diagnosis that was treated.

SECTION VI - COMPLETION OF INVOICE FORM

Block No. Description

24A. DATE OF SERVICE:

Enter the date of service in numeric month, day, year order.

24B. PLACE OF SERVICE:

Use the codes on the back of the billing form which identify where the service was performed. The codes are:

1 Inpatient Hospital
2 Outpatient Hospital
3 Doctor's Office
4 Patient's Home
5 Day Care Facility
6 Night Care Facility
7 Nursing Home
8 Skilled Nursing Facility
9 Ambulance
0 Other Location

A Independent Laboratory
B Ambulatory Surgical Center
C Residential Treatment Center
D Specialized Treatment Facility
E Comprehensive Outpatient Rehabilitation Facility
F Independent Kidney Disease Treatment Center

24C. PROCEDURE CODE:

Enter the appropriate procedure code for the service that was performed.

Family Planning providers will enter the 8-digit provider number of the professional rendering the service in description area of 24C, if different than the billing provider listed in field 31 on the claim form.

24D. DIAGNOSIS CODE:

Transfer a 1, 2, or 3 from item 23.A to indicate which diagnosis is being treated. DO NOT enter the actual ICD-9-CM code in this block.

SECTION VI - COMPLETION OF INVOICE FORM

24E. CHARGES:

Enter the usual and customary charges for each procedure.

24F. DAYS/UNITS:

Enter the number of days being billed or the number of times that procedure was performed.

24H. LEAVE BLANK:

25. SIGNATURE OF PROVIDER/PROVIDER REPRESENTATIVE:

The provider's signature or a delegated representative must sign and date the claim form. Stamped signatures are not acceptable.

DATE:

Enter in numeric format the date the claim was completed and sent to EDS for processing.

27. TOTAL CHARGES:

Enter the total charges from all lines of the claim.

28. AMOUNT PAID:

Required if private insurance payment was made.

29. BALANCE DUE:

Required if private insurance payment was made. Subtract the payment from the total charges and enter the balance due.

SECTION VI - COMPLETION OF INVOICE FORM

31. PROVIDER NAME, ADDRESS, AND PROVIDER NUMBER:

Enter the provider's name and address.

ID NO.:

Enter the provider's KMAP 8-digit provider number.

36. CLAIM NO.:

Enter the claim number, if different from the pre-printed number on the claim form. EDS will return the first seven digits as an invoice number on the remittance statement.

SECTION VII - REMITTANCE STATEMENT

VII. REMITTANCE STATEMENT

A. General

The EDS Federal Corporation Remittance Statement (Remittance Advice) furnishes the provider with an explanation of the status of those claims EDS Federal Corporation processed. The Remittance Statement accompanies the payment check and is divided into six sections.

The first section provides an accounting of those claims which are being paid by the KMAP with the accompanying payment check.

The second section provides a list of claims which have been rejected (denied) in total by the KMAP with the corresponding Explanation of Benefit (EOB) code.

The third section provides a list of claims EDS Federal Corporation received which did not complete processing as of the date indicated on the Remittance Statement.

The fourth section provides a list of claims received by EDS Federal that could not be processed as the result of incomplete claim information. These claims have been returned to the provider along with a cover letter that explains the reasons for the return.

The fifth section includes the summation of claims payment activity as of the date indicated on the Remittance Statement and the year-to-date claims payment activities.

The sixth section provides a list of the EOB codes which appeared on the dated Remittance Statement with the corresponding written explanation of each EOB code.

Claims appearing in any section of the Remittance Statement will be in alphabetical order according to the patient's last name.

SECTION VII - REMITTANCE STATEMENT

B. Section I - Claims Paid

An example of the first section of the Remittance Statement is shown in Appendix VIII-A. This section lists all of those claims for which payment is being made. On the pages immediately following are item-by-item explanations of each individual entry appearing on this section of the Remittance Statement.

EXPLANATION OF REMITTANCE STATEMENT FOR FAMILY PLANNING SERVICES

ITEM	
INVOICE NUMBER	The preprinted invoice number (or patient account number) appearing on each claim form is printed in this column for the provider's reference
RECIPIENT NAME	The name of the recipient as it appears on the Department's file of eligible Medicaid recipients
RECIPIENT NUMBER	The Medical Assistance I.D. Number of the recipient as shown on the claim form submitted by the provider
INTERNAL CONTROL NO.	The internal control number (ICN) assigned to the claim for identification purposes by EDS Federal Corporation
CLAIM SVC DATE	The earliest and latest dates of service as shown on the claim form
TOTAL CHARGES	The total charges billed by the provider for the services on this claim form
CHARGES NOT COVRD	Any portion of the provider's billed charges that are not being paid, (examples: rejected line item, reduction in billed amount to allowed charge)

SECTION VII - REMITTANCE STATEMENT

AMT. FROM OTHER SRCS	The amount indicated by the provider as received from a source other than the Medicaid program for services on this claim
CLAIM PMT AMOUNT	The amount being paid by the Medicaid Program to the provider for this claim
EOB	For explanation of benefit code, see back page of Remittance Statement
LINE NO.	The number of the line on the claim being printed
PS	Place of service code depicting the location of the rendered service
PROC	The HCPCS Procedure for the line item.
QTY	The number of procedures/supply for that line item charge
LINE ITEM CHARGE	The charge submitted by the provider for the procedure in the line item
LINE ITEM PMT	The amount being paid by the Medicaid program to the provider for a particular line item
EOB	Explanation of benefit code which identifies the payment process used to pay the line item

C. Section II - Denied Claims

The second section of the Remittance Statement appears whenever one or more claims are rejected in total. This section lists all such claims and indicates the EOB code explaining the reason for each claim rejection. Appendix VIII-B.

All items printed have been previously defined in the descriptions of the paid claims section of the Remittance Statement.